Exhibit B

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA
HUNTINGTON DIVISION

Christopher Fain, individually and on behalf of all others similarly situated, et al.,

Plaintiffs,

vs. CIVIL ACTION NO. 3:20-cv-00740

William Crouch, et al.,

Defendants.

REMOTE VIDEOTAPED DEPOSITION OF DR. STEPHEN LEVINE

DATE: April 27, 2022
TIME: 8:00 a.m. CST
PLACE: Veritext Virtual Videoconference

REPORTED BY: KELLEY E. ZILLES, RPR (Via Videoconference)
JOB NUMBER: 5176996

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of your career, right?

A. Yes.

Q. Okay. You listed 23 separate pharmaceutical company grants to study various pro-sexual medications, right?

A. Yes.

Q. Were any of these 23 grants related to the treatment of gender dysphoria in transgender people?

A. No.

Q. And were any of the grants related to the treatment, any kind of treatment of prepubertal children with gender dysphoria?

A. No.

Q. Or adolescents with gender dysphoria?

A. No.

Q. You also list in that same section in your report, Dr. Levine, that you received a U.S. National Institute of Health grant for the study of sexual consequences of systemic lupus erythematosus and that you were a co-principle investigator. Does that ring a bell, is that accurate?

A. It is accurate.

Q. Okay. And did this grant have to do with the study of anything related to gender dysphoria?

A. No.

A. Only to the extent that the grant helped us to set up the Center For Marital & Sexual Health. The Center For Marital & Sexual Health had a program called the Case Western Reserve Gender Identity Clinic, and so this was, this was not a grant for research, this was a grant for the establishment, the administrative establishment of our center that dealt with many sexual, all sexual things including trans phenomenon. We didn't in those days call it so much trans phenomenon, but we called it gender identity problems.

Q. Right. So one of the grants was used to start the Center for Marital & Sexual Health, but those five separate grants were not for the study or, or direct treatment under the Sihler Mental Health Foundation?

A. That's correct.

Q. Okay. But the Center For Marital & Sexual Health, as a clinician there you saw a wide range of patients there, right?

A. Yes.

Q. With a variety of problems related to sexuality or sexual well-being?

A. Yes.

Q. Okay. And did you treat any children with gender dysphoria at the Center For Marital & Sexual Health?

A. If I can clarify your question, by you do you mean me personally or do you mean under me as the supervisor of people who did that?

Q. Let's start with you personally.

A. Yes, I have only on a rare occasion personally treated or directly or indirectly treated a child. My center, however, over the years has, has seen children and, and I've been involved in the, the treatment as a supervisor of those children.

Q. Okay. So you've reviewed their cases by way of your supervision of clinicians at the center, but not individually?

A. That's right.

Q. Okay. And is that the same for any adolescents with gender dysphoria who were seen at the center? In the early years I'm talking about now, not in recent times.

A. Well, in the early years I occasionally saw personally an older teenager, older adolescent, but in the early years you must understand most of the patients were adults.

Q. Okay. So to your knowledge, Dr. Levine, have you received any grants to study the treatment -- I'm sorry, excuse me. Have you received any grants to study treatment for adults with gender dysphoria?

April 27, 2022. We're going back on the record at 10:36 a.m.

BY MR. CHARLES:

Q. Okay. Dr. Levine, talking about your writing credentials, you've testified previously that you were involved in drafting portions of the WPATH standards of care Version 5, right?

A. Yes, I was the chairman of that group.

Q. And besides that, have you developed -- let me back up. Have you helped to develop treatment guidelines for the treatment of children or adolescents with gender identity issues?

A. If you mean have I been part of a national or international group that tried to, to publish, that published guidelines about the treatment of these individuals, the answer is no. But in my November of 2021 article I gave, I offered my opinions about what the evaluation of adolescents and children ought to consist of. In that sense I'm hoping that would influence the guidelines of those committees who might function in the future.

Q. I see. When we spoke in September of 2021 for the Kadel vs. Folwell deposition, you said that you were working with SEGM to develop some treatment guidelines. What, what happened to those?

Q. Yes, Exhibit 01.
A. Would you give me the pages again.
Q. Sure, Page 2, Paragraph 3, so that will be the top of Page 2, the paragraph does begin on Page 1.
A. Yeah.
Q. Okay. So in that paragraph your report states that, "During this era an occasional child was seen." By this era do you mean from around 1974 to 1993?
A. Yes.
Q. Okay. And by occasional do you mean infrequent?
A. Infrequent is a good word.
Q. So is it fair to say during that period your clinic did not see many children with gender dysphoria?
A. It's fair to say that.
Q. And in your deposition on March 30th you estimated that over the course of your career you've probably only seen regularly six prepubertal children, right?
A. It's an estimate, yes.
Q. And around 50 adolescents, give or take?
A. Give or take an unknown number, yeah, ten, 12, five.
Q. Sorry, so you --
A. I've had extensive experience talking to adolescents over the course of my career, adolescents

should do about the whole problem of insuring people with this condition, I think it's beyond my expertise.

Given my medical knowledge and given my, what I would like to say my knowledge of the literature, given my knowledge of the patient, I recognize that there are lots of possibilities and I think it would be a shame for some people not to have access to that care and I think even though it's a shame, it poses new developmental challenges for the patient which they may, may very well rise to the occasion and find some other solution to their dilemma.

Q. Okay. So, so you're not offering an expert opinion about what insurance should or should not cover here?

A. Yeah, I believe that that's the policy level done at government level and insurance company level having to do with all sorts of decisions that no doctor, including Dr. Levine, has adequate background information to make that determination.

Q. But generally would it be fair to say you want what is best for your patients?

A. Yes, I do.

Q. Even if they're not wealthy or affluent, right?

A. Even if they're not wealthy or affluent or insurance covered.

A. I got it.
Q. Oh, you can see it?
A. I got it now.
MR. CHARLES: So for the record, this is Exhibit SL05, deposition of Stephen B. Levine on September 10th, 2021 in the matter of Kadel, et al. vs. Folwell.
Q. And you, you said earlier today, Dr. Levine, you remember giving this deposition last year?
A. I did, I do.
Q. Okay. And if you'll just scroll to Page 2 there. Actually, no, that's okay, Doctor, just leave it open for a minute for me, if you would. The page numbers on this document are in the upper right-hand corner.
A. I see.
Q. Okay. So if you could please scroll to Page 51.
A. Getting close, 50, 51, I'm there.
Q. Okay. So then down at line 14, it's about halfway down the page, do you see that? The page, I'm sorry, the line numbers are on the left-hand side of the page.
A. I see it.
Q. Okay. So the question was, "And using that same framing of regular, how many children, so under age 11?

Answer, in the last year? Question, yes, yes, in the last year. Answer, zero." So I just wanted to refresh your recollection of your testimony there and ask, have you seen, like has that number changed in the last seven months since you provided this testimony?

A. No.

Q. Okay. Let's see. And then on that same page, Dr. Levine, at line 19, it begins, "How many adolescents," do you see that?

A. Yes.

Q. Okay. It says, "How many adolescents in regular treatment for gender dysphoria would you approximate you've seen in the last five years individually, exclusive of your supervision of other clinicians?" At line 24, "Answer, if you ask me the question in the last year, I would have told you five or six, but since you've asked it as a five-year period, I'm at a loss to tell you whether it's 12 or 15." That's on the top of Page 52, do you see that, Dr. Levine?

A. I see it.

Q. Okay. So then has that -- so let me start first, in September of '21 you said in the last year you had seen about five or six adolescents, would that, has that number changed in the last seven months?

A. A little bit, yeah.

A. Page 51.
Q. Okay. Can you please scroll to Page 55.
A. I'm there.
Q. Okay. So at line 13 on Page 55, "Question, okay, and I'm sorry, just by recent, when was the last time you wrote a letter of authorization for a gender affirming surgery for an adult? Answer, probably 12 months ago." So have you written a letter of authorization for a gender affirming surgery in the last seven months, Dr. Levine?
A. I think the last letter -- you, I need to, I need to help you qualify your question. I have in the last seven months given my, my approval to several letters for bilateral mastectomies for members in Mass at Framingham, the correctional institution in Massachusetts. I don't know if that would number two or three, but since September the 10th I believe at least two and possibly three letters. I haven't personally written the letter, but I am the consultant to a group of team that approves such surgeries, and so the answer to the question is yes.
Q. Okay. Thank you. And to your recollection, any, any such letter outside the, outside of that context?
A. Since September the 10th?

Q. That's correct, yes.
A. Yes, I think the answer is that, no, but I believe at our center someone else has written one letter for bilateral mastectomies.
Q. Okay. Thank you. Dr. Levine, are you familiar with the, the exclusion for gender affirming surgical care in the West Virginia Medicaid Program that's at issue in this case?
MR. DAVID: Objection to form.
Q. You can answer.
A. I'm vaguely familiar that surgical care is excluded currently, but endocrine care is not excluded.
Q. Have you reviewed any documents that, that show that exclusion or was that information just communicated to you by counsel?
A. Verbally communicated.
Q. Okay. And so you're aware that there are categorical exclusions, which means that the exclusions prohibit surgical care related to the treatment of gender dysphoria regardless of a West Virginia Medicaid member's need for it or appropriateness for such intervention?
MR. DAVID: Objection to form.
Q. Let me simplify my question.
A. Thank you.

Q. The categorical, the exclusion does not investigate or contemplate whether someone receiving West Virginia Medicaid needs or is an appropriate candidate for such intervention, it just prohibits it, period?

MR. DAVID: Objection to form.

A. The categorical exclusion would include surgery for teenagers and surgery for adults, so it would cover removing the breasts or removing the scrotum of a 15-year-old who feels like --

Q. Not my question, Dr. Levine. Let me, let me rephrase again. The, the West Virginia Medicaid Program and the exclusion it maintains, which excludes surgical care for members for whom it is appropriate, it, it just excludes it, you're, you're aware it just excludes it, there's no, there's no conditional considerations or any investigation done into the member's health at all, it just, there's no coverage for that care, you understand that?

A. I, I --

MR. DAVID: Objection to form.

A. I think that's what categorical means, so I think the answer is I understand that at the moment, yes.

Q. Okay. But you don't view your testimony here in

your expert report as being in support of that exclusion or whether it should exist, right?

A. Yeah, it's my understanding that, that the lawyers who hired me wanted me to testify to the state of science in this field, and, and so I have not been involved with the legal questions, per se, or giving an opinion about those matters. As I sort of indicated to you before, I don't really feel that the, my expertise extends to how the insurance industry works and how governments and legislatives works and so forth. So I, I think the answer to the question is that I'm not considering myself to be expert on the question that you're asking me.

Q. Right. So you're, you, you are an expert about what your testimony is about though, right, and you're saying your testimony is not about whether or not that exclusion should exist?

A. Yes, I'm not offering an opinion about pro or con about that question.

Q. I see. Because you're, you're, as you say, you're not a politician or a law maker?

A. Or an insurance expert.

Q. Right. Or a public health expert, right?

A. Well, I'm a little more ambivalent about public health matters, yeah. I'm not as, I'm not, I really

think that public health is the issue here and so I, I don't want to say I'm not an expert. I'm not an expert in public health, but I do have opinions about the long-term public health of people who are prematurely having their bodies changed because I do think this has public health implications for the future of each of these, these adolescence children and young adults.

Q. Understood.

A. And adults as well.

Q. And you, generally speaking, don't advocate to deny all forms of medical intervention to people with gender dysphoria though, right?

A. That's right.

Q. Okay. I'm going to introduce another exhibit, Dr. Levine, give me just a moment.

(Exhibit 6 marked for identification.)

Q. Okay. It should be now or shortly visible, you might need to refresh.

A. I now have Exhibit 6 here.

Q. Okay.

MR. CHARLES: So I'm showing Dr. Levine what has been marked as SL06.

Q. Dr. Levine, this is a short document, please just take a minute and scroll through it.

A. Okay, I, I've scrolled.

(A break was taken at 11:33 a.m.)

VIDEO TECHNICIAN: We're going back on the record at 12:34 p.m.

MR. CHARLES: Okay. So I'm showing Dr. Levine what has been marked as SL09, an article from Society for Evidence Based Gender Medicine entitled, "One year since Finland broke with WPATH standards of care."

BY MR. CHARLES:

Q. Dr. Levine, do you see the date of publication in the left corner of that first page?

A. July 2nd.

Q. And, and the year is 2021, right?

A. Yes.

Q. So looking at the first paragraph there, I'm just going to read that, "A year ago the Finnish Health Authority (PALKO/COHERE) deviated from WPATH standards of care 7 by issuing new guidelines that state that psychotherapy rather than puberty blockers and cross sex hormones should be a first line treatment for gender dysphoric youth. This change occurred following a systematic evidence review which found a body of evidence for pediatric transition inconclusive."

And then the next paragraph, the first sentence, "Although pediatric medical transition is still allowed

in Finland, the guidelines urge caution given the unclear nature of the benefits and the interventions, largely reserving puberty blockers and cross sex hormones for minors with early onset gender dysphoria and no co-occurring mental health conditions." Did I read that correctly?

A. Yes, you did.

Q. Okay. So as this article states, medical interventions are still available in Finland for youth experiencing gender dysphoria, right?

A. On a case-by-case basis I think.

Q. And --

A. I should say on a case-by-case basis and two research centers as opposed to in any practitioner's office throughout the country.

Q. Right. But it's, it's not been completely prohibited is what I'm asking?

A. Oh, it's been, it's been, the brakes have been put on.

Q. But it's not been completely prohibited is what I'm asking?

A. That's what you and I have agreed on, yes.

Q. So it's not been completely prohibited, right?

A. Right.

Q. So then in the third paragraph beginning with,

"The qualifying criteria for gender reassignment of youth articulated in the 2020 Finnish treatment guidelines are consistent with the original Dutch protocol, but represent a significant tightening of the more recent practices promoted by WPATH." So the article describes it as a tightening of the standards which WPATH allows for, right?

A. Yes.

Q. So you, you've talked about in your report an idea of rapid affirmation treatment where you allege that diagnoses of gender dysphoria are being made in an hour and then, and then prescriptions provided for medical interventions, right?

A. Yes.

Q. Do you have, or I should say, your evidence for that is anecdotal in nature, right?

A. My evidence for that is what has been told to me by parents, what has been told to me by patients and what this, what the third paragraph of this document says.

Q. Right. So --

A. So I don't really think the answer is simply anecdotal, it's based upon a considerable consistent range of, of experiences, both of my personal experiences, of my patient's personal experiences, and

paragraph -- actually, hang on a second. Dr. Levine, let's go ahead and go to Page 26 of your report, Exhibit 1.

A. Okay. Let me, I have to scroll back. Did you say page or Paragraph 26?

Q. That would be Page 26.

A. Okay, I'm on Page 26.

Q. Okay. Okay. So, Dr. Levine, you've testified previously that you generally provide care along some of the same guidelines as WPATH, right?

A. In a general way, sure.

Q. And the difference from your view is that you require psychotherapy for some not necessarily predetermined length of time for patients that you see before you will authorize any kind of like medical intervention, right?

A. I don't want to answer that question right or wrong because embedded in the question is the word psychotherapy and I don't know what you understand by psychotherapy, I mean, you're a lawyer and I'm a practitioner of psychotherapy. And I think when a lawyer uses psychotherapy it is a certain concept about I'm trying to achieve a certain aim, you see. And in the context of the question that you've asked, you could substitute an extended period of time with the patient

working with patients.

Q. Okay. So back to my question. On some, on some level that that is, that universe of care that you are providing, which again, I think I'm still going to call it psychotherapy, but I understand your explanation that it is, that encompasses a lot that you do in your, in your clinical practice, but again, the difference for you between the Levine way, if we can shorthand, and WPATH is that you cultivate, you engage in that process as a requirement before you will authorize any kind of medical intervention for a patient for the treatment of gender dysphoria?

A. That's true.

Q. Okay. Thank you. But even still as a part of your practice as we discussed earlier, you still occasionally write letters of authorization for medical interventions, like endocrine treatments or surgical interventions?

A. Yes.

Q. Okay. Okay. Let's go back to your report, please, to Page 35.

A. I am there.

Q. Okay. And looking at Paragraph 70, let's start with Paragraph 70. I take that back, let's go with Paragraph 71 at the bottom of the page, "In recent years

WPATH has fully adopted some mix of the medical and rights paradigm discussed above. It has downgraded the role of counseling or psychotherapy as a requirement for these life-changing processes. WPATH no longer considers pre-operative psychotherapy to be a requirement. It is important to WPATH if the person has gender dysphoria, the pathway to the true, the development of this state is not. Cited Levine, Reflections, at 240. Two separate evaluations, one from Canada and one from the UK reviewed WPATH's guidelines and found them untrustworthy."

So for that footnote 113 you've cited the Dahlen study which we talked about and then there's also a citation here that says, "See also," and then there's a, a Web address, do you see that, the very last line?

A. Yeah, yeah, right.

Q. It says, "Gender report, CA"?

A. Yeah.

(Exhibit 13 marked for identification.)

Q. Okay. There should be another exhibit there for you, Exhibit 13. Just let me know when you can see that.

A. Okay. Okay.

Q. Okay.

A. Yeah, okay.

Q. Have you, have you seen this article before either on the Internet or printed out perhaps?

A. The reason I cited it is that I had read it before.

Q. Okay. And this is not a peer reviewed journal, is it?

A. This is a journalist, but if you look very carefully at the, its length and its content, it's very impressive.

Q. Okay. Is this the review from Canada that you were talking about in that sentence --

A. Yes, yes, it is.

Q. Okay. But it's, it's not a systematic review like the one from the UK?

A. It's not systematic in that it wasn't done by a community of scientists, a committee of scientists.

Q. Okay. And the --

A. It is systematic and it is a review, but it's one person's review.

Q. Right. So it's more, we were discussing the difference between systematic reviews earlier today, it's a, it's, it's not a scientific committee that's done in a, in a formal way that we were discussing, it's more akin to that latter one person reviewing things kind of --

A. It's an investigative report by a journalist.
Q. Right. And you see in the first page, Dr. Levine, it says, "The following investigative report was developed by @LisaMacRichards (a pseudonym)"?
A. Yeah, okay, right.
Q. Okay.
A. I see I'm wrong, she wasn't the journalist.
Q. So we, you don't know who this author is, right?
A. Well, her real identity?
Q. Correct, yeah.
A. No, I don't know who Lisa Mac Richards really is.
Q. Okay. So it's hard to know if she's an actual person?
A. If she's an actual person, is that what you said?
Q. What I mean to say is, because she's using a pseudonym, you can't confirm her identity is what she represents it is, right?
A. Well, she says it's a pseudonym, so I presume the rest of the paragraph is correct, that she works at a Canadian hospital and holds a master's of science degree and, yeah.
Q. But what I mean is there's no way to confirm that because we don't know what her name is?

A. It could be written by a man, I don't know, it could be written by a committee, I have no idea.

Q. Okay. Okay. So going back to what we were talking about just a few minutes ago, Dr. Levine, about your approach versus WPATH. You, you've said before, not, not necessarily today, but you've testified in other depositions that your approach has the limitation that there's not any scientific evidence or long-term studies to support it, right?

A. I think in particular what I said is that, that the status of the outcome, the outcome status and the methodologic status of psychotherapy as a first line approach to the trans adolescent has, does not have a firm evidence base just as trans affirmative care does not have a firm evidence base.

So oftentimes that's, that's, I get a question just like you ask, you just posed sort of implying that there's no evidence that my, my recommendations have a scientific proven basis to it. And that is correct, except that all other psychiatric difficulties are treated with, in our society both European and American and Asian societies by a psychotherapeutic extended evaluation and treatment approach before, with or without psychiatric medications, you see.

And so we are trying to make a, you, some people

centers have cropped up that are providing affirming care in one hour, again, we talked about the 35 parents you had talked to, you've mentioned a couple of patients you've talked to, but you don't have, or I should say what evidence can you provide me today that is, is scientific peer reviewed published data showing that this is actually what's happening in these clinics?

A. Well, if I look at Exhibit 6. Do you know what the, the first name for this center was and the name of so many of the 50 or so centers are? And it has the term gender affirming care, the clinic, you see. If you look at all of the materials in Exhibit 6, it's about support and affirmation, it's not about investigation, it's not about psychotherapy. And, and you see, gender affirming care has been taken over, it's been taking over the world's sensibilities without any scientific, first demonstrating its efficacy with scientifically respectable methods.

Q. I understand that, Dr. Levine, but that's not my question. My question is, what evidence can you point to that these kinds of interactions are happening in clinics? Is your basis that the, are you basing that on the way these centers are named?

A. I'm basing it on what they're named and I'm looking at the document that you are, are talking about.

friendly especially designed specialty clinic. Those clinics exist to take care of trans people, to give them hormones and to get them surgery, that exists.

Q. But what you're describing --

A. It exists to do psychotherapy.

Q. Okay. And what you described, Dr. Levine, is the basis for your, for this opinion, right?

A. The basis for my opinion is my collective experience of dealing, watching, participating in the evolution of the study of transsexual care over, over since 1974.

Q. Okay. So your report states that you were involved with WPATH before it was called WPATH, when it was called the Harry Benjamin --

A. Can I help you?

Q. Yes. Harry Benjamin?

A. International Gender Dysphoria Association.

Q. Thank you. And you were involved around 1999 when the 6th version of the standards of care was released, right, we talked about that?

A. Yes.

Q. Okay. And it's, it's true that you helped to draft portions of that version, right?

A. Actually, my report misstates me as the co-chair. If I remember correctly, I was the chairman.

Q. The chairman of that committee, okay. Thank you.

A. And most, with very little exception I had a significant editorial role in creating every sentence in that 21-page document.

Q. Okay. And you've testified in other depositions that even though the, there have been changes made to the standards of care in subsequent versions, you still continue to see your work reflected in those versions, right?

A. Yes, my language.

Q. Yes, mm-hmm.

A. Yeah, my language, right. In fact, the next version which came out I think three years later or two years later I think was pretty much word for word except for a requirement for one letter for endocrine treatment rather than two, which is what my committee of eight people recommended.

Q. Okay. And you've testified before that even Version 7, which is, you know, one more, obviously one more removed from Version 6, that that, as you read it much of the language you had actually still, it was still reflecting your language in that version even, even though it's a much longer document?

A. Well, yeah, I think the introduction section

about what guidelines were and, and the problems of cross culture, cross country rules affecting the laws are different and the, that we wanted this to be a information guide for, for patients and parents and wives and husbands and so forth.

I think, you know, once, once we got, I mean, I don't have it in front of me and I'm not sure I could recognize every sentence I wrote anyway, but, but they did, they did continue to use some of my sentences, some of my concepts. It was my concept that there is a difference between readiness criteria and eligibility criteria, that was one of my contributions

Q. Thank you. And, and I think also you testified in the Soneeya trial that you had asked to be involved in helping to write standards of care 8 but were told that you, in order to do so you had to be a WPATH member, right?

A. Yes.

Q. And looking back at your report -- actually, give me just a minute here. Actually, Dr. Levine, let's --

MR. CHARLES: Sorry, Kelley and Kraig, can we go off the record real quick.

VIDEO TECHNICIAN: We're going off the record at 2:26 p.m.

be trans boys or trans males.

The historic pattern throughout most of the world was 3.5 to 4 biologic males who wanted to be women to biologic females who wanted to be men dominated dramatically for decades in the '70s and the '80s and the '90s and the early 2000s. But since 2005 there's been a growing incidence of request for services and particularly request for services from girls assigned at birth who wanted to be males.

Some of us have come to in recent years call this delayed or pubertal or rapid onset of gender dysphoria, meaning it's a pubertal phenomenon because there was no evidence prior to that except in the retrospective subjective histories given by these kids that they had any indication, parents and themselves, had no behavioral indications that they were trans identified or even sort of leaning in that direction.

Q. I understand that, Dr. Levine, and I'm not talking necessarily about the, the increase in referrals, I'm talking about this phenomenon that you referenced called rapid onset gender dysphoria. So not just adolescent onset gender dysphoria, which I understand you're saying has somewhat increased since 2005, but rapid onset gender dysphoria. And I'm specifically asking what peer reviewed studies, what

papers and what research would you refer me to or is referenced in your report as evidence that this hypothesis actually exists or that there's any scientific study to support it?

A. No. 1, this is not a hypothesis, this is a demonstrated fact.

Q. Okay. Based on what, Dr. Levine, that's what I'm asking, what are the peer reviewed studies?

A. If you look up the presentations of Kenneth Zucker, if you look at papers, I can't give you the authors at the moment from Europe, this has been documented by DiAngelo I believe in Australia, by Clayton in Australia.

It seems to me there is no disagreements about this except I've heard the cynical response that what rapid onset gender dysphoria really means is that the parents have suddenly discovered that their kids have been transgender, meaning to deny the parental reports that the children were not cross gender identified prior to that, even though the kids say, well, I was never comfortable with being a boy or a girl.

Q. Okay. So you, for this contention in your report you cite one thing and that is Midgen A. Hutchinson and her study is entitled, "In support of research into rapid onset gender dysphoria." So that

was published in 2020 and I don't, I'm not seeing here any of the other --

A. One, one of the reasons you're not seeing it is that I assume that everyone understands that this is true.

Q. Well, Dr. Levine, this is an expert report and you have to include all of your expert opinions, and you're also required under Rule 26 to disclose all of the data and research that you considered for those opinions. That's the purpose of our deposition today is for me to understand and to have you put on the record what you relied on to establish your opinions, so that's what I'm trying to get at. And, and I understand what you're saying that from your vantage point as a clinician outside of the legal sphere that there are things you think are givens, but we can't operate like that unfortunately. So I need to, I need to understand, and all I see here is the Midgen A. Hutchinson study that's asking for support of, that's offering that she wants to support research into this phenomenon, not that the phenomenon has been evidenced to exist. Does that make sense?

A. Yes. May I comment on that?

Q. On Hutchinson, yeah. Let me pull it up actually.

this care and then after they lived following the care they decided that their problems have not been solved and they decided to return to the gender expression --

Q. I understand that, Dr. Levine, and I'm not actually contesting the assertion in your, in your report that detransition exists at all.

A. All right.

Q. What I'm asking about is your assertion in the latter half of that sentence that says that there is a growing number of young people who regret transition and wish to reverse it. Again, I'm just trying to understand what you're saying here and on what basis you are making those assertions.

So I'm not asserting whether or not detransitioning exists, my question is, this study did not look at how many detransitioners are there now as opposed to any other time in history, it was not a qualitative or quantitative analysis. It was a study according to the abstract here, and I'm just asking you to confirm that, about the specific needs of detransitioners, both psychological, medical, other kinds of support, right? So that's what I'm saying is this study is not, the aim is not to quantify the number of, whether the number of detransitioners is growing or shrinking or staying the same, right?

A. Yes, I can answer to your question, correct.

Q. Okay.

A. But it doesn't mean that -- I think you're missing the point. And, and by, by having me say yes, that it doesn't quantify the incidents of detransition, it's missing the point.

Q. I understand that, Dr. Levine. But if your point was, if your point in your report was detransition is a thing and here are the psychological supports that these people need, that's what you should have written, but that's not what you wrote. You wrote that a growing number of young people regret transition and wish to reverse it.

So my question to you about the article you rely on for that contention is, this article doesn't say that, this article is not a study of the growing numbers or small or diminishing numbers or staying the same numbers of people who detransitioned. That's what I'm asking you to confirm.

A. What I am confirming is that this particular paper talks about 237 people who have detransitioned and that WPATH has no serious discussion of detransition, there's no chapter on this, on this phenomenon which is extremely relevant to the care of transgender people, especially transgender young people.

The reason I cited this is 237, and the reason, the next thing, Littman is another additional 100 people. And if you, if you read closely some of the references in this particular article, there is Exposito-Campos' article talking about subreddit and the number of people who were discussing detransition.

So what I'm saying if WPATH is responsible for, for providing a scientific basis for affirmative care, they must talk about the error rate as represented by detransitioned people. And four years ago we had no idea about the, the rate of detransitioned people and today we have two studies that have been published from the UK that begin to give us a rate of detransition.

And so to me you are making the wrong point and that I have not been in error. You just have misunderstood the difference of why I cited these particular papers. These particular papers just demonstrate that detransition is a real problem and, and it is a moral and ethical and scientific problem. And that WPATH if it's going to deal with the science of transition, it has to deal with the error rates and what happens to people who detransition, you see. And so I don't, I don't have nothing more to say about that, I just think your point is quite irrelevant.

Q. Okay. Well, I'm going to continue to ask you

about evidence that you cite in your report that you use as support for assertions you're making, so I'm just going to flag that for you now. And again, this -- let's actually, let me, let me just ask one more time. This study does not speak to the numbers of people who have detransitioned now as opposed to any other time in history, right?

A. As far as I remember this paper, the answer to your question is right.

Q. Sorry, the answer to my question is -- okay, right, okay. So let's actually now that you mention it, let me just pull up really quickly the Littman study that you mentioned.

(Exhibit 15 marked for identification.)

Q. This will be Exhibit 15.

A. Okay.

Q. Okay.

MR. CHARLES: So for the record, I'm showing Dr. Levine what has been marked as SL15, "Individuals treated for gender dysphoria with medical and/or surgical transition who subsequently detransitioned, a survey of 100 detransitioners by Lisa Littman, received," well, published online 19 October '21.

Q. Okay. So looking at the abstract again, the

whether or not the numbers of detransitioners are growing, right?

MR. DAVID: Objection to form.

A. You know, I, I don't know if I should just repeat what I said before. Detransition is a phenomenon, science is only now beginning to get, we have two studies that were published within the last I think four months or five months.

Q. Okay. So, Dr. Levine, are you refusing to answer my question because --

A. Not at all, I'm answering your question, I'm answering.

Q. No, you're not.

A. Well, then ask me the question again. I'm sorry, I apologize. You want to confine me to an answer and so, so set me up for the answer you want, please.

Q. Okay. What I'm asking is, this sentence by the admission of the author was not designed to assess the prevalence of detransition?

A. That's true.

Q. Okay. Instead the purpose of this study was to identify detransition reasons and narratives in order to inform clinical care and future research, right?

A. Correct.

Q. Okay. Thank you. Okay. Let's, I'm going to

guidelines has confidence that persons who receive care according to the strong recommendation will derive on average more benefit than harm." The following sentence says, "Weak recommendations require more careful consideration of the person's circumstances, values and preferences to determine the best course of action." That sentence does not say weak recommendations mean that we're, mean that so and so is going to derive more harm than benefit or so and so, we're not sure if they're going to derive more harm than benefit. It says there, "Weak recommendations require more careful consideration of the person's circumstances, values and preferences to determine the best course of action." So my question is, where are you getting that weak recommendations mean what you are saying it means in the second to last sentence of your report?

A. Because I interpret that sentence, which we agree upon, you see. What, what that sentence really means to me, Mr. Charles, is that science cannot answer the question because we haven't done the appropriate studies and there is this issue of the long-term consequences. So reading our sentences, reading my reports we should, we're not, we don't have, we don't have to rest on science now, science can't help you, what can help you is what the patient prefers, what the

doctor's values are and what the patient's values are.

Q. Okay. So, Dr. Levine, that's your editorializing, it's not based on what the, what the, what the actual words of the guidelines are saying.

A. Well, you know, every reader, especially every professional reader integrates the scientific or these consensus documents with his own values and personal clinical experiences and what he knows in terms of other data. And so even though you say it's my personal interpretation, I, I don't want that to be demeaned. Lots of people --

Q. I'm not, I'm not demeaning it at all, Dr. Levine. I'm just making sure that you and I are reading the same words from the guidelines and that you aren't quoting something that I'm not seeing from the guidelines, that's what I mean, I'm not demeaning your professional experience at all.

A. Right. Well, thank you for that.

Q. So let me, let me ask one follow-up. You said that you thought some people read these recommendations, some, some clinicians read them and said, oh, the Endocrine Society is recommending hormones and without any, without any nuance or, or without really say understanding the various, in my view, pretty, pretty nuanced things that this guideline says. What evidence

A. This is --

Q. Well, let me just ask you, Dr. Levine, you don't speak Finnish, do you?

A. I'm an American, which means I have one language.

Q. Okay. Okay.

A. I only speak English.

Q. Okay. Are you saying you have read a translation of this document at some point?

A. Yes.

Q. And do you know if it was an official translation, a certified official translation?

A. I don't know if it was a certified one. I think I, I accessed it through SEGM.

Q. Okay. All right. Let's go, let's go back to your report, Exhibit 1.

A. God, I'm having the same damn problem again. All right. Exhibit 1, I'm going to get there. All right, here I am.

Q. Okay. And you, you said earlier that the UK was also changing some of their guidelines with regard to medical interventions for the treatment of gender dysphoria, right?

A. Yes.

Q. Give me just a second here. But the UK has also

not completely banned all medical interventions, right, they're just adjusting them?

A. That's correct, you're correct.

Q. And then are you aware of the Cass review?

A. Yes.

Q. That the UK is doing?

A. Yes.

Q. Okay. And, and as a part of that review you're aware that the, that the national, what do they call it, the National Health Service acknowledges that some children do experience gender dysphoria and will need clinical support and interventions?

A. Yes.

Q. Okay.

A. That's the clinical perception around many people, yeah.

Q. Okay. All right. Let's take a look, hopefully you still have it up, Page 51 of your report, Paragraph 103.

A. Getting there. Okay, I'm here.

Q. Okay. So in Paragraph 103 you're talking about a review by Professor, excuse me, Professor Carl Heneghan, the editor of the British Medical Journal. And the citation provided to that review is at the end of the paragraph, do you see that, footnote 165?

list that those are between $6,000 and $4,000 per year per child. Do you, do you know, Dr. Levine, how cost sharing works between West Virginia Medicaid Program and the federal government?

A. I presume that Medicaid patients who are insured by Medicaid don't pay for their medications.

Q. Okay. But I guess what I'm asking is, do you know what percentage or do you know what the cost is to West Virginia Medicaid versus what the cost is to the federal government, CMS, HHS that subsidizes the West Virginia Medicaid Program?

A. Oh, no.

Q. Okay. So you're not offering an opinion about the cost of puberty blockers under the West Virginia cost sharing plans, right?

A. You mean to the insurance company?

Q. Correct, yeah.

A. Oh, yeah, no. This is, this kind of information is very kept, very carefully kept from physicians.

Q. Okay. So not, no, making no representations in this report about the ultimate cost to the program or even to the patient, right?

A. No, we physicians don't know about things like that.

Q. Okay. So then the, in the same paragraph at the

bottom of Page 26, going into Page 27 you say, "The cost of surgeries, reoperations and occasional requests to reverse the surgeries for those who request the interventions are in the tens to hundreds of thousands of dollars with some cases reaching into the millions." But again, you're not offering an expert opinion here about the cost of surgical care for the treatment of gender dysphoria under the West Virginia Medicaid Program, right?

A. No, I'm just saying that physicians like myself have a hard time keeping up with our fields of expertise and, and Dr. Karasic is probably no exception. And when he assures the world that this is cost-effective care, I don't really think he has any basis for knowing that, for the same reasons that you are, you know, pointing to my deficiencies of knowledge.

Q. Fair enough. And, and you also don't represent that you know how much the federal government subsidizes surgeries that West Virginia excludes or doesn't exclude from its coverage under the Medicaid program?

A. I don't, I don't know at all.

Q. Okay. And you're not offering an opinion about which members or how many West Virginia Medicaid recipients might need surgery, right, for treatment of gender dysphoria, let me be clear?

A. Well, I don't think West Virginia is an exception to the international phenomenon of increasing numbers of gender, cross gender identified adolescents.

Q. Oh, no, but I'm, Dr. Levine, I'm asking about surgery specifically. You, you're not offering an opinion about how many West Virginia Medicaid members may need or be indicated for surgery for gender dysphoria, that's not an opinion you're offering here?

A. I still want to say that West Virginia is probably no exception and if we increase the number of people getting treatment and given, you know, some professionals' concepts about how to ideally treat these individuals, I wouldn't be surprised if more West Virginia citizens would be requesting surgery.

Q. But you don't know how many West Virginia Medicaid member recipients may need surgery?

A. Oh, no, I don't know that.

Q. Okay. And you can't, you can't then also know like what particular surgeries any of those people might need?

A. Oh, yes, oh, yes, I do, I can.

Q. No, no, I'm saying the individual people, you can't know what, what they need because you don't --

A. Oh, if I know if they're females --

Q. Dr. Levine, I'm talking about you're not

representing that you know what individual members might need as per their specific individual treatment? I'm not asking do you know the range of types of surgeries, that's not my question. My question is, you are not offering an opinion that you know what individual West Virginia Medicaid members, what kinds of surgery they may or may not need?

A. So if you tell me there's a person named Jane Doe and John Doe in West Virginia and that they're 20 years old and they're persistent in their transgender identity for eight years, I, you know, I can, as you said, I could pretty much predict what the first surgery would, that would be requested would be. But I would, I couldn't guarantee that I would be right because someone may want a rhinoplasty when I think they want, they would want an orchiectomy. But, you know, but I don't want to, you know, I mean, these, this is not rocket science because there are only a limited range of surgeries that could possibly be done.

Q. Okay. I guess what I mean is, treatment for transgender people for the treatment of gender dysphoria is individualized, so you're not saying I know what this particular person needs because you haven't met with them, right?

A. Well, that's right. But on the other hand --